

MDR Tracking Number: M5-04-1358-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-15-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, work hardening (initial and additional hours) from 2/21/03 through 7/3/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 2/21/03-7/3/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 15th day of April 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

April 2, 2004

Re: IRO Case # M5-04-1358

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 35-year-old female who reported injury in ___ from repetitive activity of the upper extremities. She developed pain in the neck and into the right shoulder. No neurologic deficit was found, but there was mid-spine tenderness. Therapy and medications were not of benefit, and on 7/19/02 an MRI of the cervical spine showed a 6mm disk rupture, which was essentially mid-line and showed small cord impingement, but no nerve root compression. It was noted then and subsequently that the patient's pain was increased with head and neck movement to the right, and with use of her right arm above her head. A 3/6/03 EMG was normal. The patient was treated with an epidural steroid injection in August 2003, despite a long course of physical therapy with work hardening. Based on the records provided for this review, apparently the patient's treatment between September 2002 and February 2003 consisted of chiropractic treatment with some physical therapy associated with that treatment. Physical therapy was instituted in February 2003 and pursued until it was added to by a work hardening program on 4/30/03.

Requested Service(s)

Ovs, wk hardening (initial & additional hrs) 2/21/03-7/3/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient had evidence of potential nerve root compression in the cervical spine in July 2002, and it appears from the records provided for this review the her care consisted of chiropractic treatment, with the patient not improving. The patient was then treated with physical therapy, and starting in April 2003, a work hardening program. The patient's records indicate no distinct improvement, with the pain recurring to its original extent during the therapy and work hardening sessions. It is contraindicated to continue a work hardening program when significant benefit is not being obtained. The fact that an epidural steroid injection had to be tried in August 2003 certainly suggests that there was no significant benefit from physical therapy and work hardening. To pursue physical therapy with or without work hardening for a period of more than 3-4 weeks without improvement is not reasonable or necessary treatment.

There were features, such as the patient's increased pain with turning her head and neck to the right that suggested nerve root compression as a possible source of the patient's trouble, but the records provided do not indicate proper evaluation in consultation with a spine surgeon.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.